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Some Minor Disturbances of Pregnancy

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All who practise obstetrics are, or should be, well acquainted with the major complications of pregnancy, for example; toxaemias, antepartum haemorrhage, tuberculosis, heart disease, contracted pelvis, etcetera. On the other hand, many of the minor complaints of our obstetrical patients are ignored or glossed over in a perfunctory manner. True, most of them are more annoying or troublesome, than dangerous, yet to the patient they loom large and terrible, and unless explained, or treated, tend to undermine her morale, and indirectly her physical and mental strength, so important for a normal pregnancy and labour.

He who diligently endeavours to seek out the fears and doubts and discomforts of his patients will soon gain their confidence. If he does this with their minor complaints his patients will usually co-operate more fully if struck down with some major complication.

In a short review it is impossible to cover exhaustively the many and varied disorders met with during pregnancy. The writer, consequently, has selected a few of the commoner and perhaps more troublesome ones as representative of the group as a whole.

Pain

Severe or persistent pain should not occur in any part of the body during a normal gestation. But some degree of pain, or discomfort if you like, is almost an inevitable occurrence somewhere and sometime during the "nine months of human incubation". Many of these "pains" are the result of fear or ignorance regarding the physiological phenomena of pregnancy. Relief generally follows simple explanations and solid reassurance.

Abdomen—The writer has for some time been impressed with the frequency with which patients complain of lower abdominal pain in the earlier weeks of pregnancy, when the uterus is still largely a pelvic organ. In two cases, seen in consultation. so severe was the pain that ectopic pregnancy had been suspected. Many of these cases are likely threats at abortion without bleeding, but in most the pain is dull and steady rather than crampy. It is possibly due to the rapid growth and stretching of the uterine wall plus great pelvic congestion. In some, an ovary distended with a corpus luteum may be responsible. If tubal pregnancy and threatened abortion are excluded this type of pain can be ignored, reassurance and more rest generally sufficing.

Later on when the uterus rises into the abdomen, unilateral or inguinal pain of a periodic nature is frequent and is ascribed to increasing tension on one or both round ligaments. A well-fitted support and periods of rest during the day afford the only treatment available.

Along about the 4th to 6th month right (or left) lower quadrant pain and lumbar aching may presage, or actually announce, the onset of pyelitis gravidarum. Costo-vertebral tenderness, the thermometer, and a "clumped" type of pyuria in a catheterized specimen confirm the diagnosis.

After the 6th month pain along one or both lower costal margins is common and results from undue traction of the recti abdominis muscles on the lower ribs. Intercostal neuralgia, cholecystitis, and pleurisy may be simulated. Abdominal support definitely helps this complaint.

Backache is, of course, an extremely common if not universal symptom during pregnancy. Low back pain results from a combination of factors—softening of the joint ligaments, increasing body weight with lordosis and forward shifting of the centre of gravity with excessive strain on the lumbosacral and sacrioiliac ligaments and muscles. Amelioration, if not cure, comes with advice regarding more rest in recumbency, a suitable prenatal support, attention to posture and footwear (a cuban heel is ideal).

Pain and tenderness over the symphysis pubis are not uncommon and are again due to the softening and stretching of ligaments incident to the gravid state.

Leg cramps, especially nocturnal, are often troublesome in the later months. Additional calcium and rest seldom help in the writer's experience. In the event of a cramp, if the knee is forcibly flexed and the toes dorsiflexed (passively) instant relief is usual and interferes less with sleep than massage or "walking on a cold floor".

Sudden apparent "giving way" at one or both hip-joints on assuming the standing position after long sitting or lying is a common complaint and results from increased laxity of the ilio-femoral ligaments. Little can be done for this peculiar (and to the patient, alarming) abnormality.

Numbness, tingling and other paraesthesiae frequently occur in the extremities and are probably manifestations of a mild peripheral neuritis. The writer has found Vitamin B preparations very useful in dispelling these pains.

Some gravidae complain bitterly of pain in and around the umbilicus. If one remembers that the navel is a cicatrix and less distensible than the remaining abdominal parietes, this symptom is understandable. Stretching of the abdominal skin objectively produces striae gravidarum and subjectively an intense pruritis or even pain in certain people.

Foetal movements in some women (who are probably hyperesthetic) provoke alleged pain. This is more common in multiparae with thin relaxed parietes and very active fetal thrusts.

Finally, any medical condition such as constipation with flatulence may be responsible for abdominal discomfort or even pain. Major surgical lesions such as acute appendicitis, twisted cysts, etcetera must always be kept in mind but the object of this paper excludes discussion of these conditions.

Gastro-Intestinal Complaints

Pica or perverted tastes is apparently much less common nowadays than formerly and is of little importance. **Ptyalism,** like locked twins, is very rare and the writer has fortunately had no experience of this traditionally dreaded curiosity in obstetrics. (Since preparing this manuscript a case of probable ptyalism has strangely enough come under his observation).

Nausea and Vomiting occur in fully one half of all early pregnancies. Indeed so frequent is nausea that it is considered amongst the presumptive symptoms of pregnancy. All other organic causes of vomiting must be excluded. The actiology is still unsolved. Reflex causes seem far fetched. A possible explanation is a hypersensitivity to the chorionic trophoblast or its products. This structure reaches its peak of invasiveness and hormonal secretion between the 6th and 10th or 12th weeks of pregnancy and, as is well known, this period corresponds to the usual time during which nausea persists. Such an hypothesis explains the relief following intra-uterine death or removal of the ovum, the excessive vomiting in many cases of hydatidiform mole (excessive trophoblast) and its peculiarity to the pregnant state. Such hypersensitivity, we may speculate, exists only in one half to two thirds of pregnant women (those that have sickness). Further, in those of neurotic type, the nausea and vomiting will be aggravated or less well controlled. The syndrome is **initiated** by a toxaemic process, only **aggravated** by a neurotic temperament. Some women absolutely unaware of the existence of pregnancy may have nausea and vomiting. This seems to eliminate a purely psychic or neurotic origin. Nausea and vomiting, in turn, lead to aversion to food and resultant semi-starvation. Glycogen depletion in the liver with acidosis follows and increases the nausea and vomiting. The vicious circle is thus completed.

We cannot influence the initiating factor much except perhaps by sedation. But we can prevent aggravation by (a) eliminating the neurotic-psychic factors and (b) preventing glycogen depletion.

Therapeutic Formula

1. Avoidance of constipation, fatigue, excitement and undue periods of time indoors.

2. Reduction of domestic responsibilities, family quarrels, and worry.

3. Strong firm suggestion coupled with kindly and instructive encouragement.

4. Frequent, small meals largely carbohydrate in nature.

5. Mild nerve sedatives.

6. Exhibition of vitamin B-complex preparations. The above regime seldom fails (if properly carried out) to cure the simple nausea and vomiting of pregnancy.

Hyperemesis is a different story and requires hospitalization and more intensive therapy.

Heartburn (including pyrosis, eructations and water brash) is almost as common in the latter half of pregnancy as nausea is in the first half. In spite of its incidence and distressing nature but little scientific study has been made of it. The patient experiences a steady burning or gnawing sensation behind the sternum and in the epigastrium. At times spasms occur and regurgitation of gastric contents into the mouth results. Most people ascribe it to "hyperacidity" but in nearly half of all cases studied, gastric HCL has been decreased. The consensus is that it is due to reverse waves from cardia to esophagus associated with smooth muscle spasm. Hormonal changes of pregnancy or more likely mechanical changes with upward displacement of stomach and intestines impair the downward gradient of normal peristalsis (Alvarez). Indeed in severe cases, vomiting occurs. Other local obstetricians have observed marked heartburn in the presence of breech presentation, relieved by external version, and the writer has made similar observations.

Many cases are relieved by baking soda and smaller, drier meals but an equal number are unaffected. Perhaps different cases have a different pathogenesis. HCL in low-acid cases has given relief. Vomiting in the later months is usually due to heartburn, but pre-eclampsia must be kept in mind.

Gingivitis gravidarum—An increasing sponginess and vascularity of the gums even to the development of sizeable polypoid growths from the interdental papillae is occasionally seen. Dental care, astringent mouth-washes and excision of polypi constitute the treatment.

"Canker sores" (aphthous stomatitis) yield to similar therapy plus high vitamin and protein diet and local application of a caustic.

Constipation, like backache, the bane of the biped female, yields to the usual remedies in most cases. The serious consequences of costiveness are greatly exaggerated. Many of the so-called symptoms of constipation are really the symptoms of purgation or the purgative habit. Copious water drinking, regularity of habit, good residue diet (fruit and vegetables) and the milder lubricants and laxatives are generally sufficient.

Excessive appetite is, of course, a natural expression of a healthy pregnancy but the tendency of the majority of women in the middle trimester, especially, is to **overeat.** Carbohydrate foods must be restricted at this time if excessive weight is to be avoided.

Respiratory

The upper respiratory tract (nose, nasopharynx and larynx) is normally congested during pregnancy (witness frequent epistaxis, huskiness of voice). Hence, infections such as coryza, sinusitis, laryngitis are very common, very prolonged and often severe during pregnancy. Excessive coughing may rupture the membranes in later pregnancy and bring on premature labour. A properly humid, warm atmosphere and prolonged bed rest, seem in the writer's opinion, to be of more value than all the sprays, liniments, inhalants, vaccines and sulfa drugs put together.

Cardiovascular Complaints

Dizziness, palpitation, and even **syncope** may occur at any time during gestation more often in the first half. Although anaemia or a cardiac lesion may be responsible these symptoms are for the most part merely manifestations of the marked circulatory readjustment and re-shunting of blood to rapidly growing feto-maternal tissues. Postural hypotension and spontaneous hypoglycemia must be kept in mind.

Fatiguability—This is the "queen" of complaints not only in obstetrical but, I venture to say, in all branches of medical practice. In a few cases anaemia, cardiac disease, tuberculosis, hyper- or hypo-thyroidism or some other serious organic cause is present and must be detected. In the majority, no such explanation is forthcoming. Undue worry or over-anxiety regarding the pregnancy is provocative in many cases. Often one finds that so-called fatigue is really mental boredom or emotional satiety, rather than physical tiredness. The daily routine, lack of exercise and fresh air, lack of relaxation and diversification of interests account, in the writer's opinion, for the complaint of "being tired all the time" in the majority of people. Refreshing long hours of sleep, variety, recreation, hobbies are unquestionably more successful than vitamin capsules, "tonics," correction of constipation, poor blood etcetera.

Nervous System

Drowsiness is very common in the earlier weeks and to some women is almost diagnostic of pregnancy. Mental dullness in the later weeks should make one suspicious of pre-eclamptic toxemia.

Insomnia—This complaint is most often made in the last three months. Sleep is rendered difficult by

active fetal movements or by the mechanical discomfort incident to pressure and the enlarged abdomen. Heartburn and backache and leg cramps add to the list of interfering factors. Many women have throughout pregnancy a hidden and seldom expressed fear of labour—perhaps this accounts for much of their sleeplessness. Advice should be hot drinks, baths, barbiturates and evening walks.

There are many mental and emotional changes characteristic of pregnancy but space prevents further mention here. Suffice it to say that all gravida need repeated reassurance and encouragement during the entire period of gestation. Each change, each physiological phenomenon should be explained briefly and simply, and such explanation should include the manifestations of the onset and course of labour. Much of the travail of labour is due to fear and ignorance and how easily these can be dispelled is known only to those who have made an effort to enlighten their patients.

Vaginal Discharge is a notorious cause for discomfort, nay torture, in pregnancy. The practitioner need think of three types only (excluding gonorrhoea which is a major complication considering its potentialities).

(a) If the discharge is thick mucoid white, only moderately abundant and does not irritate the skin suspect merely the increase of normal cervical secretion and vaginal desquamation resulting from stasis and excessive vascularity of pregnancy. The pH is 4 to 5 and microscope reveals but few pus cells, many Doderlein bacilli and myriads of epithelial squamous cells. Simple external cleanliness and explanation are all that are necessary.

(b) If the discharge is profuse, thin, purulent, greenish-yellow, offensive, frothy and causes cutaneous soreness and pruritus suspect Trichomonas Vaginitis. Confirm by hanging-drop and high pH (6-7). Treat by dry method with arsenic powders and tablets.

(c) If the discharge is scanty, watery, containing whitish flakes and is associated with low pH (2-4) and intense vulval pruritus suspect thrush vaginitis. Confirm with microscope and treat by dry mopping and application of aqueous gentian violet solution.

The last two types often require much care and patience in treatment.

Oedema usually of the feet and hands seldom appears until well into the second half of pregnancy. An earlier onset suggests search for cardiac or renal disease.

Later oedema is either mechanical or toxaemic in origin. The former results from venous stasis and appears first across the instep and around the ankles. The shoes or slippers are noticed getting tighter. On arising in the morning no swelling is apparent but it gradually increases through the day reaching a peak at bedtime. Recumbency diminishes or dispels this oedema. This type is worse in hot weather, in working women, in heavy obese multiparae, in twin pregnancy, and in association with varicose veins. No treatment other than more recumbency is necessary.

Toxaemic oedema is due to water-retention in the tissues. Whether toxic, hormonal or from excessive salt-retention is not definitely known. It may affect the feet, ankles, pretibial regions, hands, face, indeed any part of the body. It seldom occurs before the third trimester and may be seen even on arising in the morning. It is preceded by a steadily progressive rise in blood pressure, diminution of urinary output, undue gain of weight (5 lb. per mon.) and albuminuria in that order of development. Thus we see that it is one of the latest of the **early signs** of pre-eclamptic toxaemia and in some cases never appears at all. Symptoms such as headache, visual disorders, epigastric pain, vomiting are all **very late** manifestations and indeed may herald an impending eclampsia. They should not be allowed to occur; their development should not be anticipated.

Treatment of early toxaemia of this type consists essentially in reduction of physical activity (or even bed rest), salt-poor diet, moderation of fluid intake, reduction in fat and carbohydrate to prevent undue weight gain, free action of the bowels, and mild sedation. Vigilant attention and frequently repeated examination are musts and in the event of progressive increase (in spite of treatment) demands immediate hospitalization and more intensive therapy or even termination of the pregnancy.

Usual order of appearance of signs and symptoms in **Pre-eclamptic Toxaemia,** mild or severe.

Signs	Symptoms
1. Rising B.P.	1. Mental dulness.
2. Undue weight gain.	2. Headache.
3. Progressive oliguria	3. Visual disturbances.
4. Albuminuria.	4. Gastro-intestinal— especially vomiting.
5. Oedema.	5. Epigastric pain.

Therapeutic Formula (Pre-eclampsia)

1. Rest—preferably bed.
2. Salt-poor or salt-free diet.
3. Restriction of fluids (if edema).
4. Reduction of total food intake.
5. Mild but continuous purgation.
6. Mild but continuous sedation.

If persistent or increasing—Hospitalization with Nos. 1-6 intensively plus hypertonic intravenous injections of glucose, 10% Mag. Sulph. etcetera.

If no response in 10 days in moderate or 24-48 hours in severe cases—Induction of Labour.

Note—Although this is not a minor disorder when fully developed, it is, in the early stages when amenable to treatment and hence is detailed here.

False Labour Pains

Especially in the last 4 to 6 weeks of pregnancy the weight and pressure of the greatly enlarged uterus cause considerable discomfort in most women. Shortness of breath, flatulence, leg pains and varicose veins, pressure on bladder with frequency and urgency, difficulty in walking and haemorrhoids are examples not already mentioned in this paper. In a few cases sharp, sudden fleeting pain referred to the vagina is complained of. Frequent rest in the horizontal position and good abdominal support when erect, helps to relieve these symptoms. Sometimes if lightening is sudden the pelvic symptoms come on acutely and may be associated with cramping uterine pains at irregular intervals which closely simulate the onset of labour. These are called **false labour pains** and of course may develop apart from lightening. They annoy the patient and often the doctor who may be called unnecessarily. Frequently only the lapse of time will distinguish them from true labour pains. False pains are felt chiefly in the abdomen, come at irregular intervals, are not progressive in intensity and in an hour or two usually subside. A purgative or enema generally puts an end to them. Each pain often lasts several minutes and definite hardening of uterine wall is not noticed. True pains seldom last more than ½ to 1 minute, come at regular though decreasing intervals, increase progressively in intensity with passage of time, are felt both back and front, are associated with hardening and rising up of the uterus, sometimes with a mucoid blood

show or passage of liquor amnii and beginning dilatation of external os. Purgatives or an enema strengthen rather than drive them away.

For a few days to a week before actual effective labour pains develop, many women experience regular pains which come and go and in every respect resemble true labour pains. Only rectal examination will put one right. The writer believes that effacement of the cervix especially in primigravidae occurs gradually during the last week or so of pregnancy and in some people is associated with regular pains. But not until effacement is complete and dilatation starts can true labour be considered to have begun. If on rectal examination a long cervix is felt despite regular and even close pains it may be considered that the patient is having preliminary, or preparatory, and not true labour pains. The importance of this distinction is very great clinically. Countless women, not in real labour, are admitted to hospital and after several days of these pains the attendant either from undue anxiety or ignorance or from pressure of patient or relatives attempts to interfere (pituitrin, even Caesarean). The writer has made this error in diagnosis and sees it repeated often in hospital obstetrics. It must be carefully distinguished from and is usually confused with primary uterine inertia.

Summary

Prenatal care aims to detect and correct promptly the preventable major complications due to, or associated with pregnancy. Prenatal care can do much, also, as we have seen, to alleviate the minor discomforts peculiar to pregnancy. In recognizing and treating minor disorders we frequently are forestalling major developments; simple morning sickness if untreated may go on to hyperemesis; excessive weight gain etcetera to pre-eclamptic toxaemia; insomnia to later puerperal insanity. In every case we can improve the patient's comfort and mental and physical health and strengthen her morale immeasurably.

All this requires much time, care, patience and intelligence but the results gained more than compensate for the efforts expended and distinguish the modern science of obstetrics from the aimless witchcraft of the older midwifery.

Pleurisy with Effusion

By Donald L. Scott, M.D.

Pleurisy is usually defined as an inflammatory condition of the pleura which may or may not be accompanied by an effusion of fluid. Pleurisy may thus be dry (fibrinous), wet (serous) or purulent.

Dry pleurisy in our experience occurs mainly in association with the septic chest, although in tuberculosis the pleura may be involved without fluid forming. The term "septic chest" is a poor one but is the one commonly used to denote bronchial infections with some involvement of the surrounding lung tissues, the infection being caused by pyogenic organisms—staphylococci, streptococci, pneumococci, etc.—the ordinary inhabitants of the respiratory tract. Pleurisy due to tuberculosis is frequently wet. Inflammation of the pleura also occurs in association with pneumonia and broncho-pneumonia, and may occur over a tumour of the lung situated near the pleural surface.

Purulent pleurisy or empyema is commonly associated with the pneumonias and is caused by pyogenic organisms, pneumococci or streptococci. Empyema also occurs with lung abscess or rupture of the lung and occasionally with tuberculosis. An empyema, even of the streptococcal type, should be easily recognized because of the cloudy appearance of the fluid, the high specific gravity and by microscopic examination for which only a small sample is needed.

We are mainly concerned with wet pleurisy or serous effusion into the pleural sac. This is sometimes termed "Idiopathic Pleurisy". In our experience, which may be peculiar because of the nature of our clinic, nearly all cases of pleurisy, with an effusion of clear straw-colored fluid, are tuberculous in origin. We do, however, see a few cases due to pneumonia and other pyogenic infections where fluid forms but does not become purulent. These cases are never surgical and it is important to recognize the fluid as simply a serous effusion. The specific gravity is over 1.018 and may become quite high as the fluid element of the effusion absorbs.

A transudate of fluid into the pleural sac may confuse one at first, but the low specific gravity is diagnostic. Such transudates occur with failing heart, nephritis, etc. Effusion also occurs in conjunction with new growth. This is usually blood-stained, the blood being intimately mixed with the fluid. In our experience bloody fluid does not occur with inflammatory conditions.

Pleurisy with effusion is not a disease that can be studied by tissue examination. Its occurrence along with tuberculosis of the lung, or the occasional finding of tubercle bacilli in the fluid by various means, or the initial appearance of a positive tuberculin and the later appearance of pulmonary disease, makes us think that this kind of pleurisy is nearly always due to tuberculosis. We have observed several cases in hospital personnel known to have a negative reaction to tuberculin become suddenly ill with pleurisy and at the same time the tuberculin reaction becomes positive. Post-mortem studies of this type of case are lacking because nearly all get better—at any rate, pleurisy does not cause death. We believe, from the observation of many cases, that the initial infection is by inhalation. The site of implantation, either primarily or secondarily, is in the lung, probably towards the base, and the inflammatory reaction extends out to the pleura. The inflamed serous membrane, at first dry and painful, eventually pours out a serous exudate that hides the lung from X-ray visualization. The lesion, being small, is compressed the same as in pneumothorax and heals while the fluid is there. Tubercle bacilli are rarely found because the lesion is not an open one on the pleura, and the outpouring of serous fluid is the reaction of the serous membrane to inflammation. In pyogenic infections the lung lesion is usually larger and the organisms which are much more numerous, multiply rapidly, and they find their way into the pleural space and thus the fluid contains organisms and becomes purulent.

The symptoms are variable but not multiple. Usually there is pain which may be described simply as an ache or it may be severe and sharp. It is aggravated by a deep breath, yawning, sneezing, or a hiccough. Fever is usual and is accompanied by malaise, headache, and anorexia. Shortness of breath is unusual if the patient is at rest but some breathlessness is noticed with exertion, which exertion includes talking.

The diagnostic features are well known. There is diminished movement of the base on the affected side with absent tactile fremitus, dullness, and absent breath sounds. The X-ray confirms this

and it should not be necessary to aspirate except in unusual circumstances. Atelectasis may be confused with pleurisy, as may be pneumonic consolidation, but a careful consideration of physical findings, history and laboratory findings, should be sufficient. In young people the tuberculin test should be done. Under thirty years of age we feel that a positive tuberculin test is of significance but over thirty many of our population have had exposure to tuberculosis so that a positive reaction is not of such diagnostic value, but as the incidence of tuberculous infection becomes less, the test in older people gains more significance.

The treatment of pleurisy is that of tuberculosis—rest in bed. The fluid acts as a splint for the diseased lung and for that reason it should not be removed. There are no short cuts to the cure of tuberculosis and likewise there are none in the treatment of pleurisy. A period of from three months to a year is required. Sanatorium rest is best because of regulations and the absence of the everyday distractions of the home.

It has been repeatedly noticed how much more efficient is a Sanatorium regime of rest than any other attempt at bed rest. Febrile reaction subsides in a few days, breathing becomes normal, appetite improves, and the patient's outlook changes from that of a sick to a well person. The fluid in many cases begins to absorb almost at once.

Aspiration is performed rarely and then only to ascertain the nature of the fluid. Evacuation of a large amount of fluid expands the lung containing the lesion. Thus healing is prolonged, fibrosis of the larger lesion occurs, and, instead of leaving a small scar, sometimes invisible, a large scar is left. The pleura becomes thickened over the site and binds down the partially collapsed lung and the pleura over the base of the lung becomes adherent to that over the diaphragm. All this is akin to the adhesions found in the peritoneum due to the trauma of handling or the trauma of infection. By this series of events the patient is left with a crippling deformity of the base of the lung, poor expansion, and poor movement of the diaphragm. This crippling leaves the base of that lung exposed to all the insults of inhalation infections and foreign bodies. It fairly commonly results in localized bronchitis or even bronchiectasis.

The pleurisy that is not aspirated suffers only one trauma—the comparatively mild one of a fairly benign tuberculous infection. The inflammatory reaction is not fulminating and, if properly rested, is self limiting. The return to normal is almost complete. Strict rest of body and mind results in the complete absorption of fluid after a few weeks. The serous membrane returns to normal if one can judge by X-rays, and X-rays are our only way of judging. At any rate, in the few cases I have seen that have not been aspirated the absence of thickened pleura and the normal function of the diaphragm are a striking contrast to the chest that has been interfered with, which shows the lung obscured by thickened pleura, the diaphragm fixed, and the bony thorax indrawn—conclusive evidence of a lung bound down by adhesions, for which normal function is impossible. The rare exception to this is the case with more than minimal tuberculosis in the underlying lung, positive sputum, and a lesion that obviously needs to have collapse treatment, such as pneumothorax. Here it is permissible to remove fluid and replace it with air in order to prevent the diseased lung from expanding and becoming adherent.

In conclusion, there are three main and important points that we feel should be stressed about pleurisy with effusion.

1. Pleurisy with effusion is to be regarded as being tuberculous in origin until it can be proved otherwise.

2. We do not favour interference with pleurisy with effusion by aspiration, the best results being obtained by sanatorium rest.

3. If aspiration is necessary there should be as little interference as possible and just enough fluid withdrawn for examination purposes.

Some Clinical Notes on Polyvitamin Therapy

By H. M. Perry, M.D.

Were it not for the fact that thousands of hours and millions of dollars have been spent upon research to determine their value for the efficient conduct of the war on both fronts, Vitamins had bidden fair to be laughed off the list of useful and potent therapeutic agents. No wonder! While your ears still hum with the radio's suggestions for a more vigorous, joyful life, your eyes are taken with every form of pictorial advertising, goading you to try the new, the cheaper, the more concentrated brand of vitamin this or that. These substances have been put into hand soaps, face creams, your daily bread and your childrens' canned milk. The very sunlight is bottled so that it may be dealt out with a spoon along with the vitamin D to your eager offspring. Vitamins are very easy to swallow but what is served with them is very hard to take. Yet much that has been said about these strange, captivating food principles is true. They can in some degree be incorporated in almost any medium and can be expected to do some good even when ladled out in such a sloppy fashion.

In therapeutics, we are gradually losing the habit of administering large doses of single vitamins except in certain diseases. One seldom hears the term "shotgun therapy" applied to polyvitamin capsules, as it was in 1935. As a rule, vitamin deficiencies are found to be multiple, although the deficiency most obvious clinically may be of only one of them.

It has become apparent through clinical and laboratory research that the vitamins are interdependent and often synergistic in their action, so that a deficiency of one may lead to waste of another.

The Food and Nutrition Board of the National Research Council published a list of known vitamins and gave what they considered the minimal and the desirable daily requirements as follows:

	Daily Minimum Requirements	Daily Desirable Requirements
Vitamin A	4,000 international units	5,000 international units
Vitamin B—		
Thiamin (B_1)	1 mgm.	1.8 mgm.
Nicotinic acid (B_6)	10 mgm.	18 mgm.
Riboflavin (B_2)	2 mgm.	2.7 mgm.
Vitamin C	30 mgm.	75 mgm.
Vitamin D	400 international units	No adult dose stated

Obviously these are not the only vitamins that are necessary, but they are the only ones for which definite required amounts can be stated at the present time.

Bewildering lists of contents accompany samples, and one frequently wonders how to assess the quality of a polyvitamin capsule. Because of wartime restrictions no company is allowed to include more than 5,000 units of vitamin A and 500 units of vitamin D in a single capsule, so these two are usually present in that amount. Vitamin C can be manufactured cheaply and is usually included in quantities between 25 and 35 mgm. which supplies minimal daily requirements.

Generally speaking, the efficiency of a capsule can be gauged by the amounts of the various components of the vitamin B complex which are included. Because thiamine and riboflavin are expensive and nicotinic acid is cheap, padding may be accomplished with the last at the expense of the other two. If there is 1½ to 2 mgm. of thiamine and 2 mgm. of riboflavin the capsule is well balanced. Nicotinic acid is usually present up to 20 mgm. and that is sufficient.

In some quarters it is felt, and justly I think, that the addition of vitamin B found naturally, as in liver, yeast or rice polishings, will potentiate the action of the synthetic B fractions included in the capsule. It is known that there is a decided synergistic action between the lesser known components of the B complex and those that can be obtained by synthesis.

A polyvitamin capsule is not intended to supply a full daily dose of vitamins, but it is the cheapest and most convenient method for supplementing a diet deficient in these factors. The patient on a reducing diet or an elimination regime for allergy feels much better for such an addition. General nutritional deficiency arising from debilitating constitutional diseases, notably the arthritides, may benefit from doubling the usual dose. Such capsules may be given along with therapeutic doses of single vitamins when the latter are indicated.

In the past year the literature has contained more and more articles dealing with the mode of action of the various vitamins, their absorption and storage in the tissues both in health and disease. Consequently it becomes possible to apply intelligent vitamin therapy based on sound physiological principles in an increasing number of conditions.

Space will not permit discussion of all vitamins. Since it has been shown that vitamin B is often most poorly represented in polyvitamin capsules, I shall confine myself to a summary of the more recent ideas concerning the importance of this complex.

There is a general deficiency of vitamin B because the average Canadian tends to eat a high-carbohydrate low-protein diet, a tendency which becomes more accentuated as the income drops. Deficiency springs from one or all of the following factors: low protein intake, low fat intake, high carbohydrate intake, heavy manual labour, and excessive perspiration. Therefore it may be concluded that those doing heavy work on the pay of unskilled labourers are sure to obtain far less than the minimum daily requirements in their diet.

Vitamin B refers to a complex containing various amounts of thiamine, riboflavin, nicotinic acid, pyridoxine, pantothenic acid, inositol and numerous other components which vary in numbers and concentration with the source from which they are derived—yeast, wheat germ, rice polishings or liver. It is stored in the liver and is indicated in any disease of that organ, idiopathic, toxic or cardiac cirrhosis and hyperthyroid state.

Thiamine (B1) is produced synthetically as the crystalline thiamine chloride. It is intimately concerned with carbohydrate metabolism. Experimental evidence and clinical data have proven 0.5 mgm. to be necessary for complete combustion of each 1,000 calories represented in the diet. The classic B1 deficiency is wet or dry beriberi, but thiamine is loosely termed the antineuritic vitamin. It may be useful in doses of 5 to 15 mgm. daily in any case of neuritis, whether degenerative, inflammatory or metabolic. It is wasted if given in excess of 15 mgm. daily and a state resembling hyperthyroidism is described due to overdosage. Thus it is evident why hypothyroid states may improve on thiamine therapy alone, or combined with thyroid substitution treatment. A bright pink flush on the thenar and hypothenar eminences is a clinical sign of thiamine deficiency and is termed the "liver palm." Thiamine, like the rest of the known components of vitamin B, is far more effective if given along with the rest of the B complex.

Nicotinic acid (B_6) is specific for pellagra but may be useful in less advanced deficiency states. It is a natural vasodilator and may be given in any vasospastic disease—migraine, symmetrical dermatitis of the hands and feet and acrocyanosis, arteriosclerotic conditions such as angina pectoris, intermittent claudication or the confusional states of senile dementia. The therapeutic doses are large, 50 to 200 mgm. orally or intravenously, and are sometimes followed by a sweat, flushing in the blush areas, or induration of the skin around the elbows or knee joints. This passes off shortly and leaves no ill effects. Larger doses are tolerated better in the arteriosclerotic patient because of the decreased dilatation of thickened arterial walls. Clinically, the tongue is the best index of the earlier deficiency states. Starting with a bright pink tip, the colour may extend paramedially like two flares. The papillae are normal at this stage and the patient rarely complains of burning or pain. Next, the edges seem to shrink and become shiny, often showing the indentations of the teeth. Fluting of the edge is accompanied by marked atrophy of the muscle and mucous membrane, and burning and pain are usually present. Finally the entire dorsum may be an angry red, with atrophy of the membrane, large patches of sloughing tissue and lateral creases down the periphery from the underlying muscular atrophy. At this stage the patient is unable to eat solid food because of the intense pain it causes and the deficiency is aggravated by poor general nutrition. This is an advanced chronic deficiency and responds best to daily intra-muscular injections of vitamin B complex for several weeks followed by bi-weekly injections combined with oral administration as well as a high vitamin diet or polyvitamin capsules. No toxic symptoms due to overdosage have been described.

Riboflavin (B_2, G), although known for some time, has only recently taken its place in general therapeutic measures. It is thought to act with thiamine in carbohydrate combustion. It is known to be stored in greatest concentration in the cornea and appears to be broken down by the action of light. Ariboflavinosis is recognized clinically by radial scars or slow healing cracks at the angles of the mouth, greasy seborrhoeic scales about the naso-labial folds, and upon slit lamp examination of the cornea for invading vascular loops. Subjectively, the patient complains of intolerance to bright light and reflections from white surfaces. He describes a burning or an itching of the eyelids and a pain deep in or behind the bulb itself which is aggravated by pressure. On inspection, there may be a marginal blepharitis and injection of the sclera that resembles a vernal catarrh. These symptoms will respond in about two days to a daily dose of 5 mgm. of riboflavin combined with vitamin B complex, but therapy must be continued for several weeks to clear up all the signs. It is logical to assume that in modern offices equipped with

fluorescent lights workers would save considerable money now spent on tinted glasses if they would attend to a higher riboflavin intake while thus exposed. A therapeutic trial with riboflavin and B complex should be given to any chronic scleral injection and used as an adjunct to more specific measures in inflammatory conditions of the eye. The ariboflavinotic tongue is easily recognized by its magenta colour. This starts at the tip, extends as two paramedian streaks on the dorsum which widen until the entire tongue is involved. At the same time the papillae become swollen and the tongue looks bulky. There is no pain, burning or atrophy of muscle as noted in the tongue of nicotinic acid deficiency. Treatment is effective by mouth but the colour does not fade away for months.

Pantothenic acid used to be termed the filtrate factor of the B complex. It is probably more widely advertised in beauty parlors and barber shops than elsewhere. Given in doses of 10 to 20 mgm. daily it is thought to arrest or correct prematurely graying hair. In the cases I have observed the white hair has not returned to its original colour but has become a tawny shade and is thus less noticeable. The texture of the hair improves and it becomes less dry and brittle and shows a glossy sheen. Some patients are unable to tolerate this factor because of an acceleration of bowel activity causing a marked diarrhoea. Other patients may not show any change, good or bad, until other vitamins are added to the diet.

Pyridoxine is given in 50 to 100 mgm. doses daily for idiopathic parkinsonianism and in radiation sickness following abdominal exposure to deep X-ray therapy.

Inositol has not been released in its pure form but may be obtained for experimental use from some of the manufacturers. Clinically it is used to treat psoriasis, favoring and accelerating a remission in the disease, as it has the effect of lowering blood serum cholesterol. Wheat germ oil and soya bean lecithin contain the highest concentration of this fraction which even here is so small that they are given in large quantities and over a period of some months.

Other factors of the B complex are being sought out and separated but as yet have not been tested sufficiently to give even a preliminary rating from a clinical standpoint. In general, vitamins might be termed the efficiency factors in the body and in a future that places the accent on preventative medicine these will occupy a position of prime importance.

Hospital Luncheon Program Reports

Misericordia Hospital

Spinal Anaesthesia—Dr. J. Brener

April 12, 1944.

Dr. Brener discussed spinal anaesthesia in all its phases. Beginning with preoperative medication he warned that over-sedation removed a valuable guiding sign of cerebral anaemia. He then discussed the basic principles of, and the agents used in, spinal anaesthesia. He mentioned the indications, contraindications and dangers and dwelt upon respiratory failure, its prevention and treatment. He concluded by saying that in carefully selected cases spinal anaesthesia was safe and very satisfactory. It makes operating much easier for the surgeon and with care the risk to the patient is not greatly increased.

St. Boniface Hospital

March 23, 1944.

Spondylitis Ankylopoietica—Dr. H. Funk

Dr. Funk presented a series of cases of Ankylosing Spondylitis. This condition is frequently misdiagnosed as osteoarthritis of the spine, while in reality it is the spinal form of rheumatoid arthritis. The X-Ray picture is very characteristic. The spine assumes a bamboo-like appearance, due to ossification of the lateral ligaments, and the sacro-iliac joints usually show more or less complete fusion. The underlying condition appears to be a demineralization process in which sulphur is removed from the ligaments, which process can be arrested by X-Ray therapy. This, together with orthopedic treatment, will relieve pain in any case and improve posture in the earlier ones.

Paraplegia—Dr. J. C. Hossack

A woman aged 57 developed paresis of the legs shortly after an abdominal operation in which spinal anaesthesia was used. While still in hospital the legs were numb and weak. She was able to walk out but shortly after returning home the weakness increased and in a few months she was bedridden. This was two years ago and since then her decline has been steady.

On examination she showed evidence of a widespread cord lesion in the dorsal area. The blood count was 1,500,000 red cells and color index 1.5. The smear showed macrocytes. This suggested that she suffered from postero-lateral sclerosis due to pernicious anaemia. The history, however, suggested that the spinal anaesthetic had caused a transverse myelitis. Renal infection was also present and from this she died before liver therapy had a chance to be effective. Unfortunately, there was no autopsy and the diagnosis, therefore, cannot be certain but it is probable that she had a dormant combined sclerosis stirred up by the anaesthetic. The moral is that careful examination of the nervous system should precede spinal anaesthesia.

Large Spleen With Anemia—Dr. R. O. Burrell

A diagnostic problem was presented in the case of a middle aged woman who had severe anaemia leukopenia and enlarged spleen. She had been bleeding for some time, as a result of uterine fibroids. The bleeding had been treated by radiation. The association of low red and white counts with splenomegally suggested splenic anaemia as the cause and raised the question of splenectomy. The depressing effect of X-rays upon the blood forming apparatus raised another question as to the value of blood counts expressed was that observation should be continued following such treatment. The opinion generally expressed was that observation should be continued until the effects of radiation had passed when a more reliable blood picture might reveal the true cause.

J.C.H.

Victoria Hospital

Jaundice—Dr. D. R. Williams

A man of 63 developed moderately severe pain below the left ribs and in a day or two noticed that his skin was yellowish. For a month the jaundice waxed and waned. On examination a mass could be felt extending two or three inches below the rib margin. The mass was fixed and not tender. The age of the patient and the mass suggested cancer of the head of the pancreas. At operation a stone the size of a hazel nut was found in the common duct. Recovery was uneventful.

A.L.S.

Paget's Disease—Dr. M. Brookler

Dr. Brookler presented a 70 years old woman who complained of pain in legs and back. The pain was a dull ache aggravated by motion and present for 18 years. For 13 years the legs and right arm had been deformed. Twelve years ago X-rays showed marked sclerosis of the tibiae, femora and pelvis. The skull was thickened.

Paget's Disease is a chronic disease of bones occurring in later years, producing softening, new formation and subsequent hardening; and resulting especially in enlargement of the head, curving of the spine and curving and enlargement of the bones of the legs. A.L.S.

Carcinoma of the Breast—Dr. W. G. Newman

Dr. W. G. Newman presented a case of carcinoma of the breast in a woman of 32. He followed up the case history with a demonstration of slides. Dr. A. C. Abbott discussed the paper. He emphasized that a radical Halstead operation is worth while even in advanced cases of cancer of the breast because there is a chance of cure in a certain percentage of cases. Dr. R. A. Macpherson discussed the value of radiation before and after operation. He quoted a report published by the Memorial Hospital, New York. The experience there was that the survival rate was increased by 1.8% in those cases that were radiated preoperatively. Nothing can be done to the breast post-operatively but the axilla can be treated by cross firing which is of value in stage 2. A very mild dose will produce tissue reaction, a large massive dose will produce fibrosis and endarteritis.

Metastasis is of the bathing suit distribution in type and can be found anywhere in the femur and even in the tibia.

In stage 3 or 4 radiation may prolong life 1-2 years. Survival rates in months are better with radiation than with surgery.

In cases where tumor disappears after radiation surgery is indicated because there will be a recurrence since one can never give concentrated doses of X-ray without burning the skin. When the amputated breast is sectioned cancer cells are found.

Broder's classification is not satisfactory, the newer classification is more reliable. The stage of the growth is more important than the grade.

A.L.S.

Winnipeg General Hospital

Case Report: Abdominal Tumour—Dr. Brian D. Best

April 20th.

Dr. Best presented a lady in her middle 20's with a large protuberant abdomen. Pre-operative investigation did not yield sufficient information to make an accurate diagnosis. Four and one-half litres of straw colored fluid had been removed by paracentesis a few days prior to operation.

At operation a large cystic mass filled the pelvis with the mass running upward behind the great omentum to end somewhere in the region of the pancreas. At first view the tumour seemed inoperable, but after hours of careful and painstaking dissection the tumour was removed with exception of some minor material at the base. This tumour was a mesenteric cyst or lymphangioma. Post-operatively the patient has run an uneventful course. Intravenous fluids and bloods were given on the operating room table.

Dr. J. Gunn cited a similar case whose abdomen was opened one year later following the operation and there was no evidence of recurrence. The concensus of opinion regarding this patient's outlook was reasonably good. A full discussion followed the presentation of this case.

Correction of Alopecia Areata Following Removal of Impacted Teeth

Dr. Wm. Robb.

April 20th, 1944.

Miss A., aged 24. During a five year period this young lady began to lose her hair until she was completely bald. Eyelashes, eyebrows, pubic and axillary hairs were normal. Patient complained of severe headaches, on account of which she was advised to have an impacted wisdom tooth removed. The latter was removed on June 18, 1943. In August of the same year the patient noticed hair on her scalp commencing to grow in patches about the size of a silver dollar. At present the hair on the scalp is some 5 inches in length.

Dr. Robb mentioned a number of investigators upon the subject of alopecia. He also cited a case similar to his own that was published in the Archives of Dermatology and Syphilology, vol. 45, page 349, 1942, by Dr. James D. Grace, D.D.S., Ann Arbor, Michigan, U.S.A.

A lively discussion followed the presentation of this case.

Circulatory Adjustment with Posture

April 6th, 1944.

Drs. H. V. Rice and E. T. Feldsted gave an interesting piece of research on the use of the plethysmograph, showing circulatory adjustment of the extremities by posturizing. A number of graphs were shown demonstrating the different pressures in the peripheral vessels and showing the effect of posture and normal conditions. Blood vessels that are diseased show quite a different response to posture than normal vessels.

Refrigeration Anaesthesia

Dr. Rennie gave a clear and concise description of crymo anaesthesia. He gave the advantages and disadvantages of this type of anaesthesia. He cited a personal case of amputation below the knee by refrigeration anaesthesia. There was excellent anaesthesia during the operation and post-operative healing was uneventful. Dr. Rennie mentioned that probably the only difficulty was the possibility of slightly delayed healing following amputation. D.C.A.

Brandon and District Medical Association

Brandon Mental Hospital

March 15, 1944

A meeting of the Association was held at the Hospital with Dr. Thomas presiding and forty-five members of the Profession being present. Dr. Stuart Schultz gave a paper on Child Guidance Clinics, based on the work of the past three years during which time 2,204 children have been examined. Dr. D. C. Aikenhead, President of the Manitoba Medical Association, spoke on Contributory National Health Insurance. He outlined the development of health insurance, methods of administrative control, remuneration, and a University training Hospital.

A large group of Service men were present and took an active part in the discussion.

Two important motions were placed on record:

Moved by Dr. Stuart Schultz and seconded by Dr. H. S. Evans: "That all Medical Officers of the Armed Forces be granted privilege to exert their prerogatives as members of the Canadian Medical Association, and that this resolution be forwarded to the Department of National Defense at Ottawa."

Moved by Dr. J. Murray Matheson and seconded by Dr. Fjelstead: "That the Manitoba Sanatorium Board be requested to make a Tuberculosis survey of all residents of Brandon, and that this resolution be presented by the Chairman of the Health Committee to the Brandon City Council."

Stuart Schultz, Secretary.

Winnipeg Medical Society—Notice Board

C. M. Strong—*President*
P. H. McNulty—*Vice-Pres.*

Next Meeting May 19th

W. F. Tisdale—*Secretary*
H. M. Edmison—*Treasurer*

"For lo, the winter is past, the rain is over and gone; the flowers appear on the earth; the time of the singing of birds is come and the voice of the turtle is heard in our land." So is it written about Spring in the Song of Songs. The turtle, by the way, is the turtle-dove whose langourous cooings are replaced in our particular land by the raucous croaks of rana esculenta. In Spring birds, beasts and vegetation put on new clothes, and in harmony with this universal practice our Society dresses itself with a new Executive.

I remember very clearly, as indeed must everyone who heard it, the acceptance speech of our reigning president. When the results were announced Dr. Strong sat for a while in surprised bewilderment, or so it seemed. Then, getting to his feet he said: "Ladies and gentlemen, I am doubly and triply amazed at the result of this election. I believe that you have made a great mistake but you have laid this cross on your own shoulders and now you'll have to bear it." Surely, among speeches of the sort, that must stand unique. We have not, however, been called upon to bear any cross, so Dr. Strong's threat was not fulfilled. But his promise to serve the Society to the best of his ability he has well kept. Only those who have been associated with him on the Executive realize how faithfully, how diligently and how well Dr. Strong has served our Society. Its welfare has been his principal concern during the year now ending and when, in a few days, he lays down his office it will be with the satisfaction of leaving finished a job well done. He has been a good president.

At the meetings over which Dr. Strong has presided there has, however, been one thing missing. That is the gavel. You may recall that through the good offices of Surgeon Rear Admiral Gordon-Taylor we were presented by the Royal College of Surgeons with a fragment of the Hunterian Museum, part of which was made into a gavel. This useful and ornamental property, however, practically never appears. We have not yet got into the habit of using it, which is a pity, for it is a reminder of many things—of the London Blitz, of the danger in which we stood, of the great John Hunter, of the Royal College of Surgeons and, not least, of the fact that we number among our members, albeit in an honourary capacity, the senior vice-president of that College. I hope that this historic momento will be in evidence on May 18th.

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Among Dr. Strong's last official acts will be the conferring of Life Memberships upon three of our associates. The three so to be honored are Doctors Ross Mitchell, F. D. McKenty and H. Wadge, and all of them, you will agree, are most worthy of this distinction.

Both Dr. Mitchell and Dr. McKenty have spent many years in many capacities in the service of their fellow practitioners. So active have they been, so highly have their opinions been regarded, that their influence has been very great. Many of the advantages we enjoy today we owe to them and the extent of our debt to these two leaders would be difficult to compute.

In Dr. Wadge we honor one whose service has been of a different sort. He exemplifies the ideal practitioner who devotes his life to his patients and employs his talents at the bedside rather than in the council chamber. Those who served with him overseas speak with admiration of his quiet but very great and dauntless courage under fire. He has thus, both in peace and in war, brought honour to his Society which now seeks to do honour to him.

The April meeting was divided between Dr. R. E. Beamish, speaking on the Treatment of Essential Hypertension with Sodium Thiocyanate, and Dr. M. R. MacCharles speaking "On Appendicitis". By the time these papers will have been given, Messrs. Whitley, Roscoe & Hickson will have put the May Review "to bed" (such is their quaint expression) so any comments will have to come later.

★ ★ ★

One of my correspondents has sent me a little pamphlet which he feels should, in the interests of science, have wider publicity. The subject of this leaflet is Hayastacanosis. At first I thought, as you might think, that this was a tropical ailment or some newly discovered deficiency disease. But I was wrong. It is the name of a parasite which "is black in colour, looks like a snake and ejects venom".

This nasty little ophidian was discovered by Drs. Palfenier and Esbjorn, who photographed it and registered it under the Copyright Acts of Canada and the United States. Just how or why anyone should seek to copyright a parasite is hard to see. But then, of course, this is a very special parasite for it is none other than death itself. In the words of Drs. Palfenier and Esbjorn "Therefore, let us take death and call it a parasite". When the Apostle said "We die daily" he was speaking what Drs. Palfenier and Esbjorn know to be the literal truth for Hayastacanosis, they say, is within us from the moment of conception, and is mischievous from the moment of birth.

As we grow, Hayastacanosis squirts out a little venom and, lo, we come down with meningitis or infantile paralysis or what have you. As we grow older, bigger and better squirts give us diabetes, sinusitis, cancer, asthma, all diseases beginning with G. and so on. Of course, at any time a nauseated Hayastacanosis may spew up all its venom which naturally means curtains.

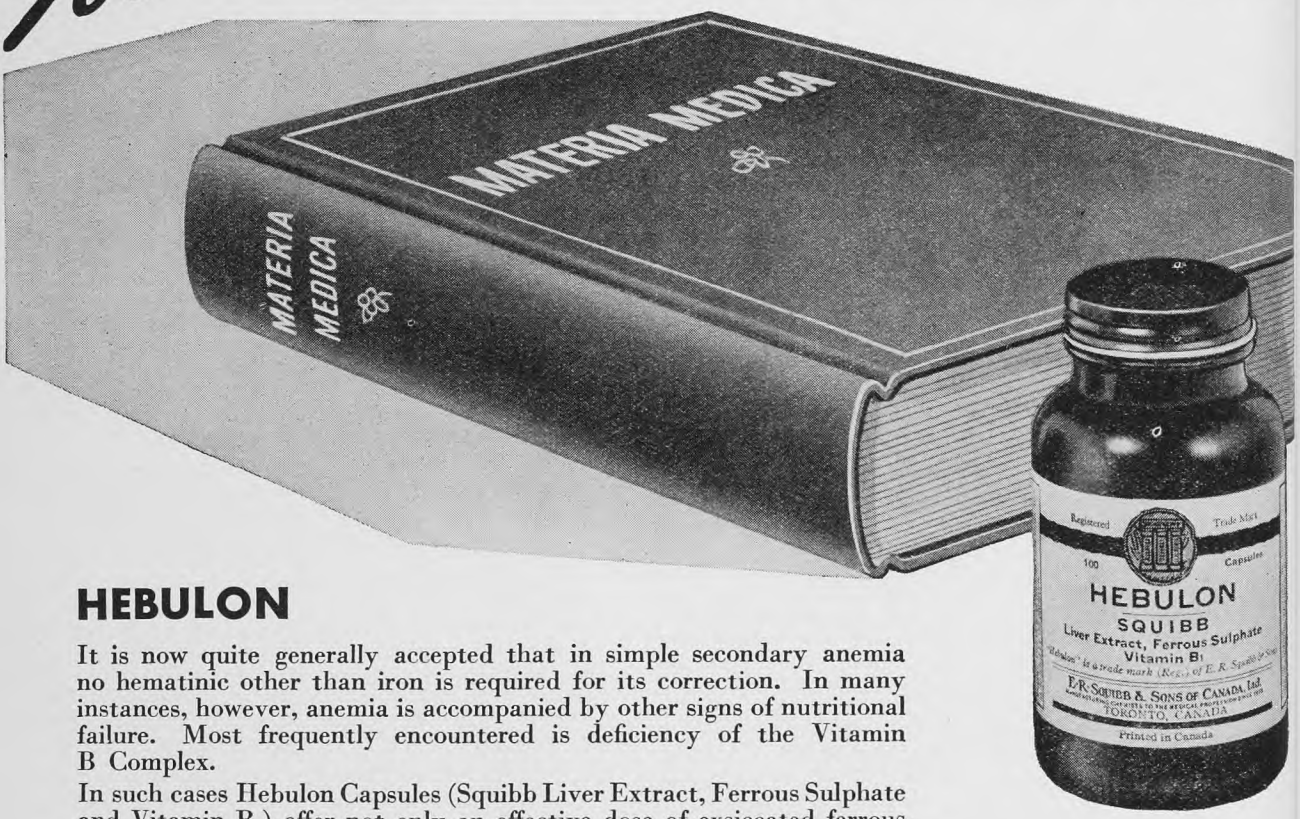
This idea is not particularly new. All primitive peoples believed, not that disease caused death, but that death caused disease. Only, they personified death as an impressive, albeit repulsive, looking god. It remained for Drs. Palfenier and Esbjorn to prove that it actually is a microscopic, poison-packing, "dark complected" little varmint that looks like a snake. Nevertheless, we must accept the inevitable. We might prefer the idea of a grim, majestic angel but death has become tangible and concrete in the form of a pesky little venom-belching worm.

In the interests of accuracy, then, we should refer to man's last enemy by its proper name. For a while, until we get used to it, this will sound a little odd. Let us practice a little. "O Hayastacanosis, where is thy sting?" "And all our yesterdays have lighted fools the way to dusty Hayastacanosis." "Aye but to Hayastacanose and go we know not where." Still the new word might in spots be useful. Claudio, I am sure, would have strengthened his argument had he answered Vincentio "The weariest and most loathed worldly life that age, ache, penury or imprisonment can lay on nature, is a paradise to what we fear of Hayastacanosis."

What does the word mean? "This snake-like parasite is to be known to the world at large as Hayastacanosis, as the word is derived from the ever common ailments, Hay Fever, Asthma and Cancer."

Well, there you are, and now that I have laid before you this most recent and precious gem from the realm of pseudo-science I suggest that you turn to the more profitable pages of this journal. J.C.H.

For the SECONDARY ANEMIA



HEBULON

It is now quite generally accepted that in simple secondary anemia no hematinic other than iron is required for its correction. In many instances, however, anemia is accompanied by other signs of nutritional failure. Most frequently encountered is deficiency of the Vitamin B Complex.

In such cases Hebulon Capsules (Squibb Liver Extract, Ferrous Sulphate and Vitamin B_1) offer not only an effective dose of exsiccated ferrous sulphate, but supply, in addition, 50 U.S.P. units of Vitamin B_1 and liver extract derived from 16 Gm. fresh liver. The capsules thus provide a convenient means of supplying not only iron, but B complex factor vitamins and hemoglobin-building substances contained in liver extract, which have been shown to be frequently needed in cases of nutritional failure.

Hebulon is supplied in bottles of 100, 500 and 1,000 capsules.

FERROUS SULPHATE WITH B_1 SQUIBB

Capsules Ferrous Sulphate with B_1 Squibb are designed for oral administration in the prophylaxis and treatment of secondary anemia, especially where the addition of vitamin B_1 is considered desirable, as during pregnancy and lactation, infancy and childhood, and in patients with anorexia associated with lack of thiamine. Each capsule contains 3 grains (0.2 gram) of ferrous sulphate exsiccated (approximately 60 milligrams iron) and 1 milligram of pure crystalline thiamine hydrochloride (333 U.S.P. units of vitamin B_1).

Tablets Ferrous Sulphate Exsiccated Squibb are intended for the prophylaxis and treatment of secondary anemias where supplementary iron alone is all that is required. The tablets are enteric-coated and contain 3 grains of ferrous sulphate or approximately 60 milligrams iron.

Ferrous Sulphate with B_1 Squibb is supplied in bottles of 100 and 1,000 capsules

E·R·SQUIBB & SONS OF CANADA, Ltd.

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Editorial

There is tendency among medical writers to stress the unusual rather than the commonplace. They take for granted that their readers are not interested in minor ailments or in the simpler questions of health, yet it is for minor complaints that most patients seek help and, not infrequently, the doctor has more difficulty in their control than when the discomfort is of a major sort. The papers this month deal with the simpler but, nonetheless, troublesome phenomena of disease, and should be very helpful. In the Hospital Luncheon Reports there is mention of both the rare and the common.

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The widely and loudly trumpeted publicity given to penicillin in the lay press raised our hopes that here at last was the sumum bonum in medicine, the therapia magna sterilans, the theriac and mithridatum which the ancients sought but never found. But as experience mounts we find that it is far from being a panacea although its value is undoubtedly great.

Meanwhile the sulphonamide family continues to grow in numbers and in reputation. The latest addition is sulphamerazine which, if we can believe Flippin, Reinhold and Gefter, is the most effective and the least toxic of all. It is absorbed more completely, is excreted more slowly and is less likely to precipitate in the kidney. For these reasons, it is the most effective remedy of the sulpha group. In cases of infection by staphylo-, strepto- or pneumococci.

The average dose is 3 grams followed by 1 gram every 4, 6 or 8 hours until the temperature has been normal for 58 hours. In severe infections the drug can be given intravenously.

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Health Insurance is the consuming interest of your President and, while the Bill is not likely to be enacted for some time, he has been active in devising means of making its practice a healthy thing for the doctors. It is his wish to keep you up to date in the doings of your Executive in the matter and future issues of the Review will contain articles especially written for your consideration and guidance. There are so many good things about Health Insurance that everyone wishes to see it established. But, unless much care and foresight are used, there is a great chance of hurtful clauses finding their way into the Bill. Therefore, there is much wisdom in the action of Dr. Aikenhead in shaping the events of the future while it is still to-day.

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Dr. R. G. Ferguson, Medical Director of the Anti-Tuberculosis League of Saskatchewan, spent Saturday, April 15th, in Winnipeg at a meeting called by the Manitoba Association of Registered Nurses and the Manitoba Hospital Association to discuss Tuberculosis and Nurses. Dr. Ferguson discussed the use of B.C.G., the tuberculosis vaccine which has been used for the past few years in Saskatchewan. He was so enthusiastic about results that plans are being made to use the vaccine in Manitoba, beginning at the Sanatorium at Ninette. D.L.S.

★ ★ ★

Your patient has no more right to all the truth than he has to all the medicine in your saddlebag . . . He should get only so much as is good for him.—Oliver Wendell Holmes.

The sick should be the doctor's books—Paracelsus.

Obituary

Dr. I. Herbert Davidson died in the Winnipeg General Hospital on March 30. Born in St. Phillipe, Que., 67 years ago, he came to Manitoba as a child, and graduated from Manitoba Medical College in 1903. For 26 years he practised at Manitou, then for 12 years was chief anaesthetist at St. Boniface Hospital. Later he occupied a like post at Deer Lodge Military Hospital. He is survived by his widow, two sisters and six brothers, one of whom is Dr. J. R. Davidson of Winnipeg.

He was an able anaesthetist and enjoyed the esteem of his confreres.

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Proposed Program

for the Ninth Biennial

Canadian Conference on Social Work

at the Fort Garry Hotel, Winnipeg, Manitoba

on May 15, 16, 17, and 18, 1944.

"The Way to Lasting Peace" will be the general theme for the Conference.

The program, as it has developed to date, has been arranged in consultation with social workers across Canada to provide for discussion of a wide range of selected subjects. The arrangement may be altered, and the list of speakers and discussion leaders is still in the making.

The response so far has been encouraging and widespread. Inquiries may be addressed to Mrs. Robert McQueen, 460 Main Street, Winnipeg.

Among the visitors attending will be: Dr. Eduard Lindeman, veteran professor of social philosophy of Columbia University's School of Social Work; Dr. Eveline Burns, of the National Planning Association, Washington; Miss Mary Judy, Association of Junior Leagues of America; and Mr. Glen Leet, administrator of public assistance, Rhode Island Department of Social Welfare, who will be in Winnipeg for a survey of Manitoba's welfare services.

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May Medical Happenings

Luncheons

4th, Thursday, 12:30, Winnipeg General Hospital.
9th, Tuesday, 12:30, Misericordia Hospital.
11th, Thursday, 12:30, St. Boniface Hospital.
16th, Tuesday, 12:30, Grace Hospital.
18th, Thursday, 12:30, Winnipeg General Hospital.
23rd, Tuesday, 12:30, St. Joseph's Hospital.
25th, Thursday, 12:30, St. Boniface Hospital.
26th, Friday, 12:30, Victoria Hospital.

Winnipeg Medical Society

19th, Friday, Regular Meeting, Medical College, 8:15.

Tumor Clinic

Winnipeg General Hospital, Every Wednesday, 9 a.m.
St. Boniface Hospital, Every Tuesday, 10 a.m.

Ward Rounds

Every Thursday, 11 a.m., Children's Hospital.

Association Page

The proposed plan of National Contributory Health Insurance is primarily for the benefit of the general public. A plan or plans the doctors may have must give the above first consideration. Great technical strides have been made in medicine during the past 25 years. Has the distribution of these new ideas lagged?

What does a community owe a doctor?

What does a doctor owe a community?

If and when the proposed legislation comes into effect (Health Insurance) there must be modern offices and hospitals with the latest in equipment for diagnosis and treatment. It would seem to follow that medical men must have the training to efficiently use this modern equipment.

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Your attention is directed to a Round Table Discussion—"The state's responsibility for health services"—to be held in the Fort Garry Hotel, Tuesday, May 16th, at 2.30 p.m.

Dr. T. C. Routley, General Secretary of the Canadian Medical Association, will present the viewpoint of organized medicine. Hon. R. P. Vivian, Minister of Health and Public Welfare, Ontario, will preside. A dominion representative from Agriculture and Labor will also take part in the discussion.

It is hoped that a large number of medical men will make a point to attend this discussion.

Dr. Routley, according to our present advice, will be in Winnipeg late Monday afternoon, May 15th, all day Tuesday, May 16th, and part of Wednesday, May 17th. Your Executive is arranging a meeting for Tuesday evening, May 16th, when Dr. Routley will give a talk on Health Insurance. The meeting will also be open for discussion. This is a most important meeting and it is hoped there will be a large turn-out of medical men. Please do not leave this to some other man to decide. Come yourself and add your weight to the discussion. D.C.A.

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Saskatchewan Health Insurance Act

The following is an extract from Bulletin No. 5 of the Central Health Insurance Committee, Saskatchewan C.P. & S.

The Chairman advised that before entering upon the Agenda, a special report was to be considered in the matter of Bill No. 69 being a Saskatchewan Health Insurance Act, which on Friday, the 31st day of March, was placed on the Members' desks and received first and second reading that day, and the third reading of which was held up by reason of a special delegation of eight doctors having attended at the Legislature and requested that an opportunity be given the profession to register a protest and make representations prior to the final passing. He asked the Secretary to make the report, which was as follows.

The College had offered its findings, information and conclusions to Premier Patterson last January, who acknowledged the offer. A Special Committee had prepared a Brief and had presented it to the Cronkite Reconstruction Council on March 9th. Mr. Cronkite had asked that the Committee submit specific answers to definite questions within a month.

Absolutely no indication was given the profession at any time that a Bill was being contemplated, and the doctors were taken completely by surprise when on the day before the closing of the Legislature, the Bill was put through.

Dr. Gareau opened the discussion by protesting to the Minister, who had his Deputy with him, the fact that no opportunity was given to make representations on this Bill and the hasty manner in which it was rushed through in the last hours of the Legislature. He offered to confirm our representations and submit them to the Minister in writing at a later date. He then asked the Secretary to act as spokesman for the delegation.

The Secretary repeated the protest of Dr. Gareau, and stated that the medical profession felt that it had a just grievance in receiving no opportunity to present their views after they had given the subject of socialized medicine close attention for several years, and after a Special Committee of twenty-one men of the College having made an intensive study for the last ten months. This Committee had arrived at definite conclusions on questions of principle and some firm ideas on incidental questions, and to have now a Bill foisted on them so rapidly without a hearing, was startling and embarrassing.

Dr. Argue emphasized that if this Bill were presented to the members of the College, not a single one would accept it, and that it will cause an uproar in the profession.

Dr. Uhrich, the Minister, then replied, and reviewed the history behind this Bill as follows:

The Legislature (NOT the Government) had set up a Select Committee to study Health Insurance during its preceding session. This Committee held many meetings and received Briefs from all groups. Later, the Reconstruction Council was set up to continue the study and was still continuing its work. The Select Committee however, had brought its report into the Legislature and recommend the principle which this Bill adopts. He stressed the point that the Government had no alternative but to take the action it did, and as the Committee's report did not come down until late, the Bill could not be presented earlier than drafts had been made before the one presented.

The Minister insisted that as the profession had filed briefs both to the Select Committee and the Cronkite Reconstruction Council, both of which are designed to prepare a preliminary survey to set up a health security plan, the profession had had ample notice and should not have been taken by surprise.

Secondly, the Bill in itself is not a Health Insurance Act in the sense that it brings any plan or scheme into effect, but that it is merely an initiating, enabling Bill, and as such quite innocuous. The Commission is going to enquire into and make tentative arrangements for a health insurance plan, and when its report comes in, then the Government of Saskatchewan will enter into an agreement with the Government of Canada, if Parliament has passed its contemplated Health Insurance Act.

The Minister admitted that no provision was made for representatives from the various groups, but he insisted the Bill did not prevent any group from having representation. Just as it does not say that the Chairman of the Commission shall be a doctor, it does not say on the other hand, that the Chairman shall NOT be a doctor. He closed in saying that there was nothing startling in the Bill, and there was no reason to be either alarmed or suspicious.

C A S E H I S T O R Y

HEMATIC HIMMLER, S.S.

Patient was discovered in the monkey house at the Tiergarten by one "Iron Hermann", who noticed one of the occupants wearing spectacles. Investigation revealed this to be a human.

When first interviewed, a pronounced euphoria was evident, but the reading of despatches from the eastern front had a rapid sobering effect and it was possible to elicit the following:

Father was a noted alcoholic and died of a fall from a pink elephant. Financial embarrassment and inability to work, enforced sobriety upon patient until the age of 23. His first debauch occurred in Munich in 1923 when he participated in a beer hall orgy with a party of dissolute companions. Following this, he entered upon a period of prolonged alcoholism, subsisting mainly upon rubbing alcohol, canned heat and bay rum. He finally acquired a police post and the steady wages enabled him to change his beverage to paregoric.

While on a spree in July, 1934, he organized a "blood bath" in which a number of his friends were most unwilling participants.

He believes that a bomb concussion sent him into the predicament in which he was found, but is unable to understand why his presence in the monkey house should have gone unnoticed for three days.

DIAGNOSIS: Patient was referred to Dr. Ley of "Joy of Living Department", who pronounced him a clearly defined example of Polandemia (Polish great-grandmother).

TREATMENT: Dr. Ley suggested that the Reich was not altogether suited to the patient's constitution. Immediate departure for South America was recommended and Dr. Ley insisted that he should accompany the patient in order that he might supervise the complete cure. Frequent transfusions of pure Aryan blood are to be continued.

Personal Notes and Social News

Dr. and Mrs. J. Murray Matheson of Brandon are happy to announce the birth of a son (Allen Carlyle) at the Brandon General Hospital on February 21st, 1944.

★

Surg.-Lieut. W. J. Elliott, Jr., R.C.N.V.R., has been posted from sea duty to the Royal Victoria Hospital, Montreal, Que., for an X-Ray course.

★

Dr. and Mrs. Alex. W. Andison of Preston, England, announce the birth of a son on March 24th, 1944.

★

The Executive and Members of this Association wish to express their deepest sympathy to Dr. N. A. Laurendeau on the loss of his wife who died, after a lengthy illness, on April 8th, 1944.

★

Surg.-Lieut. Q. D. Jacks, R.C.N.V.R., and Mrs. Jacks are happy to announce the birth of a son (Terry Ross) at the Winnipeg General Hospital, on March 29th, 1944.

★

Captain and Mrs. Arthur Stevenson spent a short vacation in Winnipeg at the home of Mrs. Stevenson's parents.

★

Major and Mrs. G. H. Ryan of Hamilton, Ont., wish to announce the birth of a daughter, born March 28th, 1944.

★

Dr. and Mrs. E. J. Washington have returned from a vacation spent at Vancouver and Victoria, B.C.

★

Dr. and Mrs. J. E. Isaac are happy to announce the birth of their second daughter on April 8th, 1944, at the Winnipeg General Hospital.

★

Dr. Owen C. Trainor has been nominated for the position of second vice-president of the Graduates Society of McGill University. This nomination is tantamount to election.

★

Dr. and Mrs. H. Lamontagne are celebrating the birth of a daughter, born April 12th, 1944, at Grace Hospital.

Dr. Charles Hunter and Miss Marjorie R. Warren, daughter of Mr. Henry Warren of Winnipeg and the late Mrs. Warren, are to be married on Wednesday, May 3rd, 1944. Before returning to Winnipeg they will spend two weeks visiting places of interest on the Pacific coast.

★

Major Herbert J. Scott, R.C.A.M.C., formerly specialist to the army reception centre, M.D. 10, Fort Osborne, has been transferred to the military hospital at Petawawa, Ont., where he will act as eye, ear, nose and throat specialist.

★

Dr. W. F. Abbott and his two children are spending a vacation at Oakbay Beach Hotel, Victoria, B.C.

★

Dr. Ida Armstrong has returned from the West Coast where she was a guest at the Oakbay Beach Hotel, Victoria, B.C.

★

Dr. J. M. Ridge has returned from Edmonton, Alta., and is now practicing at Hodgson, Man.

★

Dr. J. C. Elias has re-entered civilian practice as resident physician at St. Boniface Hospital.

★

Dr. Alexander Gibson has returned to Canada from Hairmyres, Scotland, where he was Chief Orthopedic Surgeon at the Canadian Red Cross Hospital to which he was appointed for a six month's period. Dr. Gibson has now resumed civilian practice.

★

Dr. and Mrs. Roy J. Stewart are happy to announce the birth of a son (Peter John David) at the Winnipeg General Hospital, April 17th, 1944.

★

Their gift is not in golden coin:
In higher values must we measure
Lives offered up in Freedom's cause
While we but lend an earthly treasure.
With all we have we must support
Our men and women in this fight
That peace may come again to Earth
And all the world be ruled by right.

J. N. Stephenson.

Letters to the Editor from Overseas

No. 6 Cdn. C.C.S., C.A.O.,
22nd March, 1944.

Dear Dr. Hossack:

Thank you very much for your letter of 15th February and the February copy of the Manitoba Medical Review. I particularly liked the Association page by Dr. Aikenhead. As a member of the Health Insurance Planning Committee of the R.C.A.M.C. (Overseas) I, as well as all others, have been looking for as much information as possible on developments at home. We have been getting the medical publications regularly from most of the other provinces and are now glad to have the Manitoba one and I am looking forward to your report of the discussion with representatives from Labor and Agriculture at your meeting of 18th February. Any information you can send on these matters will be appreciated and will be put before the Committee. The results of the questionnaire circulated by the Manitoba Medical Association are the only definite indication we have so far received here of how the rank and file of doctors at home feel about Health Insurance. I am using it as the basis of a questionnaire for the Medical Officers in the formation which I represent. The same information will be collected from M.O's. of all formations and the results will be sent to the Executive Committee of the C.M.A.

We have received Harry Botterell's report on his visit home when he presented the memorandum prepared by the Overseas Medical Officers—report of which you will have seen in the C.M.A. Journal of February—and now feel fairly well in the picture as to what is going on at home.

Thank you again for sending the Review and please convey greetings to the Winnipeg and Manitoba Medical Societies.

T. E. HOLLAND.
No. 18 Canadian General Hospital, C.A.O.

★

March 26, 1944.

Dear Doctor:

Your idea of sending over the Manitoba Medical Review is an excellent one. It serves as a pleasant reminder that there are friends and colleagues who are thinking about us, and also brings with it numerous little items of medical news that are not ordinarily contained in the letters received from home.

The life over here is not at all unattractive, especially to those of us who have sufficient work to keep us out of mischief. With a reasonable amount of work to do, one can, without feeling conscience-stricken, take advantage of the generous opportunities the army provides for travel, both for recreational and professional purposes. The railway services are still excellent—almost up to peace time standards. What deficiencies there are exist in the arrangements for heating on some lines and in the absence of facilities for obtaining food on practically all. Recently it was my privilege to be a guest at the wedding of a colleague. Most of the day had to be spent in travelling forth and back with the result that an early A.M. breakfast and a supper after 11 p.m. had to suffice for the day. That, however, was a minor discomfort to one who had succeeded in adding a little weight since coming over here, rather than reducing, as had seemed more probable from the information that was available some months ago before we set forth.

Opportunities for professional journeys are freely given. Courses are available in London at frequent intervals and are attended by us at very little personal cost. Frequent clinical meetings are arranged, both among our hospitals and under the auspices of local bodies. It has several times been possible to arrange to attend meetings of the Royal Society of Medicine. Once every month an inter-allied conference on War Medicine is held in London, to which each hospital sends representatives. We have had the privilege of hearing such men as Gordon Gordon-Taylor, Watson-Jones, Elliott Cutler, Sir James Walton, Air Commodore Clark, etc., etc., at these meetings.

In our unit we are at present dealing almost entirely with British patients with an occasional Pole, Netherlander, and a very occasional American. The British soldier is a splendid patient, usually intelligent, always co-operative and invariably well disciplined. With few exceptions these boys are openly pleased at being sent to a Canadian institution and so we feel that not only for that reason, but also to maintain the good impression they have of our hospitals, it behooves us not to let them down.

We have several Winnipeg nurses with us, including N-S Allen, W. G. H., McLeod (Misericordia), Chapman and Piloski (St. Boniface). Cecil Clark has recently joined his new unit and is temporarily located a mile or so from us. It has been our pleasure as a unit to entertain him and in turn to be entertained by hearing from him of the experiences of No. 5 in Sicily and Italy.

Winnipeg looms large in the thoughts of us all, and when the day comes to return it will be a glad and welcome day—provided that first we have had the privilege of doing something for the boys who are soon to do so much for us.

Best regards to yourself and all good wishes to the Winnipeg Medical Society.

Sincerely,
ART HAY.

★

2nd Division,
1 Cdn. Convalescent Depot, C.A.O., C.M.F.

My Dear J. C. H.:

Thanks for the "Reminder of Medical Winnipeg," as you call it. I probably need it. I must confess my thoughts of Winnipeg chiefly concern the state of health of my cocker spaniel, Nigger, the height of the spring waters in the Assiniboine and possible ill effects of same on my forty odd feet of river bank, whether the moths have gotten into my blue pinstripe suit in the attic—and finally how many helpings of my aunt's delicious banana cream pie I'm going to stow away the first week after I'm home.

Speaking of parcels, I was almost tempted to ask "What parcels?" — but with characteristic restraint and sympathy for your finer sensibilities, decided to refrain from making such a query. Instead, let me urge you to send your parcels to someone in a better position than I am at present to appreciate them—or I should say, a worse one; the meals which we enjoy, in a mess run by our British allies, are most excellent and satisfying. So, sending parcels of edibles to me would be analogous to transporting carbonaceous fuel to Newcastle.

As for supplying you with some "personal facts" "of interest to my friends", I beg to observe that, judging by recent references to your "gossip column" —you don't seem to be doing too badly on your own. I refer to your no doubt dreadfully funny allusion to my belated periotomy. You may, if you wish, inform your readers that I am now re-conditioned and in excellent shape.

All the best, my Caledonian 'amico',
G. H. Evoy, Capt.

27 Mar., 1944.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1944 Feb. 22 to Mar. 25	1944 Jan. 30 to Feb. 26	1943 Feb. 28 to Mar. 27	1943 Jan. 31 to Feb. 27	TOTALS Jan. 1 to Mar. 25,'44	TOTALS Jan. 1 to Mar. 27,'43
Anterior Poliomyelitis	1	----	1	2	1	7
Chickenpox	292	246	115	165	868	548
Diphtheria	14	11	28	35	34	83
Diphtheria Carriers	1	3	3	3	8	8
Dysentery—Amoebic	----	----	1	----	----	1
Dysentery—Bacillary	----	----	1	1	----	3
Erysipelas	7	8	8	5	22	19
Encephalitis	----	1	1	----	2	2
Influenza	9	15	103	113	58	254
Measles	731	270	283	161	1118	542
Measles—German	64	50	3	10	121	13
Meningococcal Meningitis	1	2	4	3	6	10
Mumps	327	329	548	603	843	1588
Ophthalmia Neonatorum	----	----	----	----	----	----
Pneumonia—Lobar	----	11	31	18	36	67
Puerperal Fever	----	----	----	1	----	1
Scarlet Fever	322	269	140	108	858	293
Septic Sore Throat	4	3	5	9	9	14
Smallpox	----	----	----	----	----	----
Tetanus	----	----	----	----	----	----
Trachoma	----	----	----	1	----	2
Tuberculosis	55	49	77	46	125	142
Typhoid Fever	----	----	1	2	----	6
Typhoid Paratyphoid	----	----	----	----	----	----
Typhoid Carriers	----	----	----	----	----	----
Undulant Fever	----	1	----	2	1	2
Whooping Cough	36	27	227	134	85	528
Gonorrhoea	93	159	118	158	391	450
Syphilis	55	42	43	39	145	127
Meningococcal Meningitis Carriers	----	----	----	4	----	6

DISEASE	*738,000 Manitoba Feb. 27-Mar. 25,'44	*3,825,000 Ontario Feb. 27-Mar. 25,'44	*906,000 Saskatchewan Feb. 27-Mar. 25,'44	*2,972,300 Minnesota Feb. 27-Mar. 25,'44	*641,935 North Dakota Feb. 27-Mar. 25,'44
*Approximate Populations.					
Actinomycosis	----	----	----	----	----
Anterior Poliomyelitis	1	----	----	1	----
Meningococcal Meningitis	1	18	7	28	9
Chickenpox	292	1674	179	----	----
Diphtheria	14	9	3	20	3
Dysentery—Amoebic	----	----	----	5	----
Bacillary	----	----	----	----	----
Erysipelas	7	8	6	----	3
Influenza	9	198	8	8	274
Leth. Enceph.	----	----	----	----	----
Measles	731	2483	325	6318	770
German Measles	64	200	240	----	----
Mumps	327	1132	54	----	35
Ophthal. Neonat.	----	----	----	----	----
Puerperal Fever	----	----	----	----	----
Scarlet Fever	322	963	89	881	209
Septic Sore Throat	4	7	----	----	5
Smallpox	----	----	----	----	----
Trachoma	----	----	3	----	3
Tuberculosis	55	200	46	----	33
Typhoid Fever	----	1	----	1	2
Typh. Para-Typhoid	----	1	----	----	----
Undulant Fever	----	4	----	18	----
Whooping Cough	36	212	32	86	15
Diphtheria Carriers	1	----	5	----	----
Gonorrhoea	93	433	----	----	19
Syphilis	55	392	----	----	20

DEATHS FROM COMMUNICABLE DISEASES

February, 1944

URBAN—Cancer 45, Pneumonia Lobar 8, Tuberculosis 8,Pneumonia (other forms) 7, Influenza 2, Syphilis 2, Whooping Cough 1, Hodgkin's Disease 1. Other deaths under 1 year 13. Other deaths over 1 year 179. Stillbirths 11. Total 277.

RURAL — Cancer 16, Pneumonia (other forms) 14, Tuberculosis 10, Influenza 7, Pneumonia Lobar 3, Scarlet Fever 2, Syphilis 2, Whooping Cough 1, Hodgkin's Disease 1. Other deaths under 1 year 11. Other deaths over 1 year 97. Stillbirths 12. Total 176.

INDIANS — Influenza 6, Tuberculosis 2*, Whooping Cough 2, Pneumonia (other forms) 1. Other deaths under 1 year 1. Other deaths over 1 year nil. Stillbirths 1. Total 13.

* Whites living on Indian Reserves.

Dipththeria, with 14 cases reported is a disgrace to a Province with our small population.

Measles are becoming epidemic in Manitoba, especially in Winnipeg. Saskatchewan is the only one of the five with a reasonably low figure.

Scarlet Fever is decreasing in Winnipeg but increasing in the Province. It is very mild and suspected cases should be considered as cases and isolated as such if we are to prevent further spread.

Septic Sore Throat seems to run hand in hand with scarlet fever but in smaller numbers of cases.

Gonorrhoea shows a slight decrease and syphilis a small increase. These vary from period to period but the yearly figures will be significant.